

# Emotional Factors in Physically Handicapped Children

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FROM THE VERY BEGINNINGS of medicine there has been interest in the problems of persons with physical handicaps, congenital or acquired. In more recent years there has been a growing interest in the emotional and psychological aspects of this problem. At the annual meeting of the American Orthopsychiatric Association last year, there was a panel discussion of the problem of rehabilitation of physically disabled persons, and emphasis was put upon the relationship of all the members of the rehabilitation team, such as physician, psychiatrist, psychologist and social worker. At the Fifth International Mental Health Congress held in Toronto, Canada, in 1954, a morning was devoted to a panel discussion of "The Mental Health Needs of Physically Handicapped Children." The present brief report will attempt to bring attention to some of the important emotional factors as they have been observed in our work with physically handicapped children and their parents at the Reiss-Davis Clinic for Child Guidance.

In the past year the author has engaged in psychiatric diagnostic consultations on children with the following physical handicaps: Congenital club feet, congenital heart defects, coarctation of the aorta, congenital weaknesses of eye muscles, causing various forms of strabismus, cystic fibrosis of the pancreas, severe anomalies of the genitourinary tract, leg shortening and deformity as sequelae of poliomyelitis, severe skin conditions such as generalized psoriasis, lupus erythematosus, alopecia and many forms of eczema; undiagnosed atypical convulsions, and questionable cases of mental retardation.

The patients came to the clinic through the usual channels of referral—from pediatricians, from school physicians, nurses and teachers, from psychiatrists and psychologists in private practice, from other clinics and social work and family service agencies. Some of the patients came without referral, having learned of the clinic from friends or neighbors. The presenting complaints in this group of physically handicapped children included the following: (1) learning problems, such as deficiency

• The staff of the Reiss-Davis Clinic for Child Guidance has been concerned with the emotional factors in physically handicapped or chronically ill children. It is felt by the staff that work with these children must include not only the known procedures to improve or correct their physical condition, but also efforts directed toward preventing or removing any evidence of emotional or psychological crippling.

The symbolic or unconscious meaning of the disability is of great importance in this work. Attitudes of the parents may seriously interfere with the handicapped child's ability to develop his maximum level of functioning and adjustment. Individual and group psychotherapy was found of value in helping these parents.

in reading or arithmetic although having average or above average intellectual abilities; (2) behavior disorders such as antisocial acts in the classroom or neighborhood, some truancy and some hyperaggressive acts; (3) phobias, including fears of the night, darkness, or animals; (4) severe separation anxieties involving inability to be separated from home or, more specifically, from mother; (5) enuresis, manifested by occasional or nightly bedwetting; (6) passive, withdrawn states with progressive isolation from peers and family; (7) immaturity reactions, characterized by behavior, learning and play of a much younger age level.

As can be seen on the surface these complaints fall into the same general pattern of those of non-physically handicapped children who are taken to a child guidance clinic. It remains for the diagnostic interviews, psychological tests and, later, actual psychotherapy to reveal in what way the physical handicap has played a role in the child's emotional development and subsequently in the symptom formation. Of interest also is the question of the mother-child relationship and the ways the physical handicap has influenced this relationship. It was into this latter area of mother-child relationship that some of the psychotherapeutic energies were directed, in addition to starting individual psychotherapy for those physically handicapped children for whom it was considered necessary. Some of the pertinent emotional attitudes that were found to be of importance in both of these areas—that is, therapy

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with the mothers and therapy with the children—are here presented.

Betty, 11 years of age, was referred because of increasing difficulty in relating to her schoolmates, a growing complaint of “being different and unable to keep up with the other girls” and a general air of unhappiness. In the history it was noted that Betty had had poliomyelitis at age 6, with the sequela of large muscle group atrophy of one leg, causing shortening and a noticeable limp. Also in the history was a statement that Betty was an only child and that she lived alone with her mother who was divorced from Betty’s father. The mother was employed and supported Betty and herself from her wages. However, her employment made it difficult for her to enter Betty’s life in school activities or extracurricular events.

Betty’s mother had had a period of individual psychotherapy in another agency several years before.

It was decided to start Betty in twice-weekly sessions of psychotherapy. At first all of Betty’s verbalizations pointed to the atrophy of her leg, which in her mind was the cause of all her difficulties. She maintained that her limp kept her from playing with the other girls. “They can run faster, walk better and so they get picked on the teams and I am left out all the time.” From this there then emerged a series of questions and inquiries devoted to answering, “Why did it have to happen to me?” As the therapist allowed the material to develop further he noted that Betty was becoming involved in revealing her own fantasied reasons for the poliomyelitis and later physical handicap. It became clear that this was understood by Betty as a punishment inflicted on her.

Slowly, in response to questions and comments, Betty revealed that she believed children, especially girls, were punished for daring to masturbate. As this was discussed she felt free enough to begin to reveal some of the content of her masturbation fantasies. Here for the first time she allowed some of her feelings of dissatisfaction with her own genitals to become known. Soon it became clear that much of the complaint of “being different from the others” had its root in her feelings of girls being different from boys, and therefore less capable. The atrophy of the limb and resultant limp were thus seen to have provided her with a good situation onto which she could project these underlying feelings associated with the impairment of ability that she suffered. Shortly, however, it could be demonstrated to her that in spite of her disability she was being accepted by her schoolmates. She was able to compete with them in many ways even though not able to run with the fastest of them. In this way she could see that her own feelings had interfered with the further development of her social relationships.

As a general statement it can be said that there are specific frustrations related to different age groups. Separation from the family and restriction

of mobility have great impact on preadolescent children. An adolescent reacts much more to interference with the fulfillment of his interests and the realization of his talents. In Betty’s case we have an example of the impact that puberty can have, with its increasing concern in the body, its anatomical changes and its physiological functions. Under the impact of the physiological changes of normal puberty, Betty was again subjected to the psychological conflicts she had in regard to her body. By way of summary, the therapist’s understanding of Betty’s situation was as follows: Feelings of being different, of inability to compete or keep up with her peers, and general unhappiness with her state were on the surface presented as due to the physical handicap she had. In therapy she revealed that the handicap served her by providing a site onto which she could project deeper underlying emotional conflicts regarding her body and its role. Time is too short to demonstrate other feelings that were also projected onto her handicap. However, once she was freed of these deeper feelings she could make a much better adjustment to the reality of her handicap and accept its limitations on her performances as well as allow herself to develop whatever abilities she could.

Jack, aged 6, was brought to the clinic because he was unable to adjust to any classroom procedure in public schools. He was found untestable by the usual psychological tests administered to determine intelligence and personality structure. His speech was at times incoherent, irrelevant and filled with repetitive phrases or words. He made little or no contact with adults or children, seemed withdrawn and preoccupied with inner fantasies. Quite often he muttered, “Me dead, me dead!” The general impression was one of severe retardation with question of mental deficiency.

As work with him in individual psychotherapy three times a week began, the therapist heard more and more of the theme, “Me dead—you dead—me dead!” This alternated with a playing out in his therapy of violent explosions from without and some explosive reactions that seemed to originate from within his body. Gradually the inner explosive reactions were followed by scenes of death or destruction. However, Jack had formed an attachment to the therapist and was eager to be with her for his treatment sessions.

Jack’s mother informed physicians at the clinic that he was scheduled soon to have routine immunization injections, whereupon the suggestion was made that a complete physical examination be done at the same time. When the examination was carried out, severe coarctation of the aorta was noted, with no pulse in one arm and the temperature of the lower limbs 5° F. below normal. An operation to correct the coarctation was scheduled. In the meantime, psychotherapy was continued by

way of preparing the patient for the operation and sustaining him in convalescence. It was learned that owing to his very retarded appearance and behavior, all the possible dire consequences were discussed in his presence in the hospital where he was examined. The period of psychotherapy immediately following this cardiovascular consultation was again filled with the theme of destruction and death. As to the role the disturbed circulation played in the psychological development of the patient, it is conceivable that it not only brought about the changes in body temperature and pulse, but also interfered with the development of a normal body image. It will be of great interest to observe this boy after operation to see what effect improved circulation will have on his general psychological development.

Let us turn now to the work with the parents—more specifically, the mothers—of many of these children with physical defects or handicaps. A few of the mothers are receiving individual psychotherapy, but a larger number of them are in group psychotherapy. Like other investigators who work in this field, the author found the mothers quite often responding with deep feelings of guilt, blame and self-accusation when confronted with a congenital defect, birth injury or chronic illness in their children. These mothers, just as Betty did, posed the question, "Why did it happen to me?" And each in her own way out of the experience of her past, her own cultural influences and attitudes and her own childhood fantasies, supplied herself with an answer to that question.

An interesting reaction on the part of some of the mothers in psychotherapy was an attitude of denial of the existence of the handicap as a physical entity and an insistence that the problem was primarily psychological in nature. The kind of turning away from facing the reality that confronts them is well known in the case of parents who go from one physician to another, to various clinics, institutions, cultists and quacks, constantly seeking support of their wish to evade the situation. Perhaps the wish to consider the handicap or disability as entirely psychogenic was somehow determined by the fact that they were in a psychologically oriented setting at the moment and were reaching out, there, to get a psychological basis for the situation that confronted them. A psychological basis for the symptom would mean a chance for reversing the situation; an organic basis would mean in most instances a hopeless, irreversible process.

Oftentimes the wish to avoid facing the defect in the child stems from the parents' feeling that a defective child reveals some shameful weakness of their own. Many of the mothers spoke of the embarrassed feelings they had whenever they had

to be in public with their child, especially if they were to be in a new and strange setting. It was clear that they were concerned with the appearance or behavior of the child being reflected onto them as parents. One mother whose child had a disfiguring skin condition said, "I can't imagine how anyone, especially children, could ignore that skin condition." Because she could not ignore it, or because she had so much feeling invested in it, she was unable to accept that others might regard it differently. Often this attitude was encountered in certain mothers: "My child is so different from other children his age, because of his handicap, that he can never make any kind of adjustment in our society." This overdetermined reaction to the real situation that confronted her naturally interfered seriously with her child's ability to attain whatever potential he had. The contributing elements to this overdetermined reaction were to be found in the mother's own emotional and psychological development, especially in that area that dealt with her earlier awareness and reaction to differences in body, in sexual anatomy, in order of birth within the family, in preferred roles in relationship to one or the other parent. One mother said: "Isn't there always a difference in the way brothers and sisters are treated? Aren't brothers always treated better?"

Quite often a mother was able to recognize that an attitude she now had toward her child with a handicap was a repetition of an attitude she had encountered as a child. One mother who became aware of the fact that she took care of her children only because she considered it her "duty" to do so, suddenly recognized that this was the feeling she had had as a little girl—that her own mother took care of her, not out of love, but only out of a sense of duty. When these mothers were asked how they felt about having the additional care of a child with a handicap, their usual reply was that feelings did not enter into it at all; this was just a responsibility forced upon them and it was their duty to care for the child.

The hostile, punitive feelings of some mothers toward a handicapped child is very lightly disguised. This can be seen at times in the extreme rigidity with which they hold their child to certain prescribed routines, a restricting diet or a painful schedule of medication. Others are able to conceal it in an attitude of leaning over backward to a point of sacrificing their own lives completely, responding to the slightest need or demand of their handicapped child, often to the detriment of other members of the family. Quite often a very concerned, overprotective attitude serves to conceal ex-

tremely hostile and aggressive feelings. The anxiety and overprotectiveness of some of these parents keep the child from ever gaining an awareness of his own capabilities and limits and the child then develops with a shortage of social experiences and must of necessity remain in close attachment to his mother.

The presence of a chronic disease or a congenital defect in a child certainly makes it more difficult for any parent to carry out his parental role. The dependence of all infants and young children is of necessity increased in the case of a physically handicapped infant and young child. This increased dependence quite often provokes in the parents severe feelings of hostility with wishes to be rid of this added burden. This is immediately followed by intense feelings of guilt, and thus a vicious cycle is set in motion. It can readily be seen how this merges into the whole topic of the normal, acute physical illnesses and various needs for surgical operations, such as tonsillectomy. Here, too, the effect that the illness or the operation has on the child and on the parents has been studied and reported in terms of the psychological factors involved.

In the setting of work with these mothers at the clinic, such things as the following are often heard: "Many times I wished that in the next surgical procedure or bout of infectious illness, my child

would die." Or, "I didn't think I could take any more of it and found myself wishing he had died or had not been born." It is the feeling of all who do psychotherapy with these mothers that freeing them of guilt for having such feelings and wishes makes easier the task of relating to their child. Also of importance for those who are involved in psychotherapy with physically handicapped children is the matter of countertransference. Too great an identification or too great a sympathizing or empathizing with these children or their parents seriously interferes with the needed objectivity that is so valuable in helping these children to reach their potential level of development.

In conclusion, it can be said that (1) The work with the physically handicapped or chronically ill child must include efforts directed toward preventing or removing any evidence of emotional or psychological crippling. (2) In addition to the real nature of the disability or handicap, its symbolic or unconscious meaning to the child and parent is of great importance. (3) Attitudes and feelings of parents toward these disabilities can seriously interfere with the full development of the potential in these children. (4) Treatment of these children in child guidance clinics is an extension of the fundamental approach in medicine—that is, treat the person and not the disease.

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